AZIZAH ABDUL MANAN & ORS A

v.

DR NORLELAWATI AB LATIP & ORS

HIGH COURT MALAYA, JOHOR BAHRU B
ABDUL RAHMAN SEBLI J
[CIVIL SUIT NO: 21NCVC-11-03-2012]
27 SEPTEMBER 2013

TORT: *Negligence - Medical negligence - Ectopic pregnancy - Deceased complained of abdominal pain - Condition of deceased - Conservative management approach - Whether deceased suitable for such approach - Failure to immediately deal with deceased's life-threatening condition - Deceased suffered from upper respiratory throat infection - Operation carried out under emergency situation - Deceased died about seven months later due to sepsis secondary to pneumonia and sacral sore - Deceased's consent for operation - Whether defendants absolved from liability - Whether deceased's death could be traced back to risk created by defendants in managing ectopic pregnancy - Whether damages awarded* C D

TORT: *Negligence - Damages - Medical negligence - Ectopic pregnancy - Deceased suffered from upper respiratory throat infection - Operation carried out under emergency situation - Deceased died about seven months later due to sepsis secondary to pneumonia and sacral sore - Whether deceased's death could be traced back to risk created by defendants in managing ectopic pregnancy - Claim for funeral expenses, bereavement, loss of support, nursing care, pain and suffering and medical expenses - Whether damages awarded* E F

The deceased, who complained of bleeding and had spotting on her pad, was admitted to Hospital Sultanah Aminah Johor Bahru ('HSA') on 13 February 2009. After taking her medical history, the doctor's impression at HSA was to rule out ectopic pregnancy with differential diagnosis of early pregnancy. The deceased was seen and examined by the first defendant. After performing certain medical examinations, a decision was then made by HSA to manage her pregnancy conservatively or sometimes referred to as expectant management. It meant that the doctors at HSA did not operate on the deceased but instead, waited and watched on how the ectopic pregnancy evolved. On 14 February 2009, the deceased was reviewed and was noted to have the same abdominal pain with associated tenderness and vaginal bleeding. Whilst managing her conservatively, the plan was also to carry out G H I

an emergency laparotomy. Days passed by and the conservative management was proceeded with whereby the hospital waited for the ectopic pregnancy to rupture but the deceased's condition remained the same. On 20 February 2009, a scan which was conducted showed, *inter alia,* an empty uterus. The impression this time was failing ectopic pregnancy of unknown location. The deceased was then discharged. On 24 February 2009, the deceased was admitted at HSA where she complained of, *inter alia,* abdominal pain and on the following day, another transvaginal scan was done which showed that the deceased had considerable bleeding from the pregnancy. The deceased was then planned for laparotomy as a leaking ectopic pregnancy case. On the same day, an operation was scheduled but after assessing her condition, the anaesthetist found that the deceased was having throat irritation and non-productive cough for two days prior to admission which was not noted by the doctors in the obstetrics and gynaecology ward earlier. The deceased was explained as to the danger of anaesthesia which was due to her upper respiratory throat infection ('URTI') but the paramount urgency for the laparotomy was also explained and she consented to the anaesthesia and surgery. During anaesthesia, difficulty in intubation was encountered. Unfortunately, complications set in and the deceased developed bronchospasm which eventually led to pneumonia. The deceased's condition worsened and she was managed in the intensive care unit where she was diagnosed as suffering from left lung collapse. On 4 March 2009, at the request of her husband, the deceased was sent to the Johor Specialist Hospital ('private hospital') where she was diagnosed as having post-operative nosocomial pneumonia with septicaemia. In view of the mounting expenses, the deceased was then transferred back by her husband to HSA. She remained in this hospital until 6 August 2009 when her husband was advised that her condition would not improve and there was to be no further treatment. She was then discharged and on 3 September 2009, the deceased was readmitted to Hospital Sultan Ismail where she passed away on 5 September 2009. The cause of her death was due to sepsis secondary to pneumonia and sacral sore. The plaintiffs filed a suit for negligence against the defendants and claimed for damages. The key issue that arose for determination was whether the deceased's death could be traced back to the risk created by the defendants in the way they managed the ectopic pregnancy during the period of her admission at HSA.

Held (allowing plaintiffs' claim; damages awarded accordingly):

(1) The third defendant's version that the location of the deceased's pregnancy could not be established was false as it went against all findings and recordings in the medical notes of the deceased. The undeniable truth was that the location of the pregnancy was known. The deceased had pain in her lower abdomen and she was bleeding *via* her vagina. It was clear that she was clinically symptomatic throughout her stay at HSA. The source of the pain and bleeding could not be anything else other than the ectopic pregnancy. (para 19)

(2) There was evidence of an ectopic pregnancy in the right fallopian tube during the six days of the deceased's admission. Hence, ample opportunity was there for HSA to deal with this life-threatening condition but they did not do so. Instead, the deceased was sent home on 20 February 2009 and when she came back four days later, they were forced to carry out the operation under an emergency situation when she already had an upper respiratory tract infection. Further, the deceased was not the right patient for conservative management approach since, *inter alia,* (i) there was repeated evidence (ultrascans) that it was an ectopic pregnancy; and (ii) from the time of her admission until her discharge, the deceased showed two cardinal symptoms of ectopic pregnancy, *ie,* constant complain of pain in the right iliac fossa and continued bleeding through the vagina. (paras 23 & 24)

(3) The deceased was not managed appropriately by the doctors at HSA during the period of her admission. The deceased had suffered the consequences of a lost chance when the doctors failed to operate on her when the opportunity and indications were there to do so. Further, when the deceased came back to HSA after being discharged on 20 February 2009, it was obvious that her ectopic pregnancy had leaked and she was suffering from URTI. (para 25 & 33)

(4) The risk of anaesthetic complications was created by the defendants when they failed to operate on the deceased immediately or so soon after it was confirmed on 17 February 2009 that the deceased was having an ectopic pregnancy and when the condition was optimal for her to undergo the operation. Thus, it was negligence by omission. If surgery had

been performed before her discharge on 20 February 2009, the anaesthetic complications would not have arisen and the surgery on 25 February 2009 would not have been necessary at all. While it was true that the URTI that the deceased contracted after her discharge on 20 February 2009 was something beyond the defendants' control, the necessity to perform the emergency operation on 25 February 2009 was something that could easily have been avoided. (para 39)

(5) By omitting to operate on the deceased before discharging her on 20 February 2009, the defendants had provided the causative link to the anaesthetic complications which eventually led to the deceased's death. Further, the throat irritation and non-productive cough for two days that the deceased was having prior to the emergency surgery should have been observed by the doctors on 24 February 2009 when the deceased was re-admitted. However, this was not done and no treatment was given for her URTI. The fact that bronchospasm was a risk of operation which had been explained to the deceased and that she had consented to go ahead with the operation could not absolve the defendants from liability if otherwise they were negligent in creating that risk. On a balance of probability, the defendants were liable in negligence for the death of the deceased. (paras 39)

(6) As for damages, the court awarded, *inter alia,* (i) RM5,000 for funeral expenses; (ii) RM10,000 for bereavement (s. 7(3A) and (3B) of the Civil Law Act 1956); (iii) RM43,200 for loss of support to the deceased's parents; (iv) RM86,400 for loss of support to the deceased's children; (v) RM3,400 for nursing care of the deceased; and (vi) RM150,000 for pain and suffering (s. 8 of the Civil Law Act 1956). The deceased suffered pain and suffering in the hospital for seven months until she died. (paras 41, 42, 43, 44 & 60)

(7) The deceased was not immediately taken to the private hospital and was admitted to a government hospital between 24 February 2009 to 4 March 2009 before the family, in desperation and disappointment with the care given there, decided to take her to the private hospital. Although the treatment at the private hospital could not be completed due to the family's inability to meet the costs and the deceased subsequently died, their attempt to save her by transferring her to the private hospital was still a reasonable action under the

circumstances. Based on the Court of Appeal decision in Civil Appeal No. J-01-113-03/2012, this court allowed the plaintiff's claim for RM142,515 for the medical expenses incurred at the private hospital. (paras 51, 54, 56 & 62)

Case(s) referred to:
Bolam v. Friern Hospital Management Committee [1957] 2 All ER 118 ***(refd)***
Chong Pik Sing & Anor v. Ng Mun Bee & Ors [1985] 1 CLJ 332; [1985] CLJ (Rep) 70 FC ***(refd)***
Devadass Raju v. Tham Soon Kum & Ors [2013] 7 CLJ 178 HC ***(refd)***
Dominic Puthucheary & Ors v. Dr Goon Siew Fong & Anor [2007] 5 CLJ 38 CA ***(refd)***
Foo Fio Na v. Dr Soo Fook Mun & Anor [2007] 1 CLJ 229 FC ***(refd)***
Foong Yeen Keng v. Assunta Hospital (M) Sdn Bhd & Anor [2006] 1 CLJ 608 HC ***(refd)***
Hum Peng Sin v. Lim Lai Hoon & Anor [2001] 4 CLJ 185 CA ***(refd)***
Jennifer Anne Harper v. Timothy Theseira [2009] 2 CLJ 499 HC ***(refd)***
Marappan Nallan Koundar & Anor v. Siti Rahmah Ibrahim [1990] 1 CLJ 32; [1990] 1 CLJ (Rep) 174 SC ***(refd)***
Pang Ah Chee (M.W) v. Chong Kwee Sang [1985] 2 CLJ 221; [1985] CLJ (Rep) 236 FC ***(refd)***
Payremalu Veerappan v. Dr Amarjeet Kaur & Ors [2001] 4 CLJ 380 HC ***(refd)***
Rogers v. Whitaker [1992] 175 CLR 479 ***(refd)***
Wilsher v. Essex Area Health Authority [1988] All ER 872 ***(refd)***

Legislation referred to:
Civil Law Act 1956, ss. 7(3A), (3B) 8

Other source(s) referred to:
Atkins Court Forms Malaysia, Vol. 9, p. 152

For the plaintiffs - N Jegatheesan (R Jayabalan with him); M/s John Ang & Jega
For the defendants - Zaliha Mohd Janis (Pushpa Arasi Federal Counsel with her); M/s AG's Chambers

Reported by Kumitha Abd Majid

JUDGMENT

Abdul Rahman Sebli J:

The Facts

[1] This is a medical negligence claim arising from the death of the late Suraya binti Rahmat ('the deceased') at Hospital Sultan Ismail Johor Bahru on 5 May 2009. She was 31 years old at the

time of her death. The train of events that led to this tragic episode was set in motion when she was admitted to Hospital Sultanah Aminah Johor Bahru ("HSA") on 13 February 2009. She had on that day been referred to the hospital by a private Obstetrics and Gynaecology ("O & G") specialist Dr Chu Ah Onn (PW1) after she complained of bleeding for the previous six days and spotting on pad. Her urine pregnancy test had shown positive result, which means she was pregnant. After taking her medical history the HSA clerking doctor's impression was to rule out ectopic pregnancy with differential diagnosis of early pregnancy. Ectopic pregnancy is pregnancy outside the uterus and differential diagnosis is diagnosis that one could consider after having formed a provisional diagnosis. According to Professor Kulenthran Arumugam (PW2) who is the Senior Consultant in O & G at the Universiti Malaya Medical Centre, ectopic pregnancy is a life threatening condition to the mother as it has the potential to bleed and bleed severely. He said every doctor should know it is a potential killer and that when there is sufficient ground and evidence of ectopic pregnancy especially if the patient is symptomatic, ie, pain and bleeding, the benefit of doubt must be given to the patient and the doctor must intervene.

[2] After her admission, the deceased was referred to the O & G department of HSA and was seen and examined by the first defendant Dr Norlelawati binti Ab Latip (DW3). Her last menstrual period was recorded as in early January and this was confirmed by DW3 in cross examination. According to her it was the deceased herself who gave the information. A transvaginal scan (ultrasound) showed right hypoechoic mass, and an empty uterus. The impression again was to rule out ectopic pregnancy. At 4.15pm on the same day a repeat scan was done and it confirmed an empty uterus, an extra uterine adnexal mass measuring 2.1 x 1.9cm and a possible gestational sac within it measuring 0.9 x 0.8cm. Both ovaries were seen to be normal. The physical findings were tenderness over the right iliac region with vaginal bleeding and lower abdominal pain. The deceased was counselled on the clinical and scan findings and her decision was not to have diagnostic laparoscopy "for the current moment." Diagnostic laparoscopy is a procedure whereby a telescope is passed through the abdomen, gas insufflated and a clear view of the abdominal contents obtained to ascertain the diagnosis. A decision was then made by HSA to manage her pregnancy conservatively or sometimes referred to as expectant management. It means the

doctors at HSA did not operate on the deceased and instead took a wait and see policy and watch how the ectopic pregnancy evolved. What they did was to monitor the deceased's serial pregnancy hormone or beta hCG ('bhCG') every 48 hours. Beta hCG is like a hormone that is secreted by the growing foetus and that is why when a female wants to diagnose pregnancy she goes to the pharmacy to test her urine and it becomes positive (evidence of PW2). The deceased's bhCG was done at Gribbles, a private laboratory as HSA did not have such facility. The initial test showed that her serum bhCG was 296 1U/L.

[3] On 14 February 2009 when the deceased was reviewed at 8am and 8.45am she was noted to have the same abdominal pain with associated tenderness and vaginal bleeding. Whilst managing her conservatively the plan was also to carry out emergency laparotomy if symptoms of ectopic rupture occurred and the vital signs deteriorated. In other words an operation to remove the ectopic pregnancy would be done immediately if there were symptoms of a rupture and deteriorating vital signs. Laparotomy is a procedure whereby a cut or incision is made in the abdomen and the required surgery performed using surgical instruments. It is a major operation that requires general anaesthesia.

[4] On 15 February 2009 and 16 February 2009 the deceased continued to have vaginal bleeding with continued right iliac fossa pain and tenderness. On 17 February 2009 another scan was done. Again the uterus was shown to be empty but this time organised blood clots were seen surrounding the extra uterine gestation sac. The sac measured 1.06 x 1.13cm corresponding to four weeks and one day of pregnancy. At 2.30pm on the same day a diagnosis of right tubal ectopic pregnancy was made. Nevertheless despite this firm diagnosis of ectopic pregnancy, it was decided to continue with conservative management, presumably in line with their policy of waiting for the ectopic pregnancy to rupture. On 18 February 2009 the deceased's condition remained the same, ie, abdominal pain, bleeding and the impression was still ectopic pregnancy. However on 19 February 2009 the right iliac fossa pain was noted to be less.

[5] Then on 20 February 2009 the deceased complained of passing out products of conception (POC) and increased abdominal pain and bleeding. The POC was sent for histopathology test and marked as 'urgent'. According to DW3

the purpose of the test was to see whether there was presence of foetus in the uterus. She agreed under cross examination that the test would indicate whether the POC was a result of ectopic pregnancy or pregnancy inside the uterus. The histopathology report was however never produced at the trial. There is therefore no way of knowing what the test result was but the fact that it was marked 'urgent' means that it was important for the treatment of the deceased such as to decide whether an emergency laparoscopy or laparotomy was to be done. Another scan that was done on the same day again showed an empty uterus and a right adnexal mass measuring 2.6 x 2.0cm with an irregular gestation sac measuring 0.7 x 0.6cm. The impression this time was failing ectopic pregnancy of 'unknown location'. The deceased was then discharged at her request with DW3's blessing. A bhCG was to be repeated on 24 February 2009 and she was also to be reviewed by the doctor on 26 February 2009.

[6] On 24 February 2009, the deceased was seen at the Emergency Department of HSA at 6.43pm and was admitted to the O & G ward. She complained of abdominal pain, nausea, shortness of breath and palpitation. Her bhCG reading had increased to 11581U/L. The following day, ie, 25 February 2009 another transvaginal scan was done at 12.05pm and it showed plentiful free fluid, a reference to considerable bleeding from the pregnancy. It was only then, after a long last that she was planned for laparotomy as a leaking ectopic pregnancy case. This was a clear seven days after a firm diagnosis of right tubal ectopic pregnancy was made on 17 February 2009. At 8.50pm on the same day she was sent to the operation theatre. Here the anaesthetist assessed her as having throat irritation and non-productive cough (cough without any sputum or phlegm) for two days prior to admission. This strangely was not noted by the doctors in the O & G ward earlier. The deceased was explained the danger of anaesthesia due to her upper respiratory throat infection ('URTI') but the paramount urgency for the laparotomy was also explained and she consented to the anaesthesia and surgery. The laparotomy was done by a medical officer and so was the anaesthesia. During anaesthesia, difficulty in intubation was encountered and the medical officer had to call the anaesthetist for assistance. Unfortunately complications set in and the deceased developed bronchospasm which eventually led to pneumonia.

[7] During the surgery a leaking fallopian tube was noted and 100ml of blood was found in the peritoneum leaking from the right fallopian tube. Right salpingectomy with adhesiolysis was done. Post-operatively the deceased's condition became worse. She was managed in the intensive care unit ('ICU') and then transferred to the ICU of the labour ward. She was diagnosed as suffering from left lung collapse and was managed jointly by physicians and anaesthetists. On 28 February 2009 she was re-transferred to the ICU with a possibility of nosocomial pneumonia. Her condition worsened and on 4 March 2009 at the request of her husband (PW4) she was sent to the Johor Specialist Hospital ('JSH') where she was managed by a team of specialists. She was diagnosed as having post-operative nosocomial pneumonia with septicaemia and was treated with multiple antibiotics. Despite aggressive treatment there was no improvement in her condition. She developed complications of pulmonary fibrosis, pneumothorax and pleural effusion which required chest tubes and high ventilator settings.

[8] On 30 March 2009 in view of mounting expenses she was re-transferred by her husband to HSA. Here she developed sacral bed sore. She remained in this hospital until 6 August 2009 when her husband was advised that her condition would not improve and there was to be no further treatment. She was then discharged and taken home with oxygen and feeding tubes inserted. On 3 September 2009 she was re-admitted to Hospital Sultan Ismail where she passed away on 5 September 2009, approximately seven months after her admission to HSA on 13 February 2009. The cause of death was sepsis secondary to pneumonia and sacral sore.

[9] It is important to keep in mind at this point that the deceased did not die due to leaking or ruptured ectopic pregnancy. She died due to complications from bronchospasm which developed during anaesthesia while she was on the operating table at HSA on the night of 25 February 2009.

The Issues

[10] Two issues call for consideration, namely:

(1) Whether the plaintiffs have proved negligence on a balance of probability against the defendants in the treatment rendered to the deceased from the date of her admission on 13 February 2009 to her operation on 25 February 2009.

(2) If the answer to issue (1) is in the affirmative, whether the plaintiffs have proved on a balance of probability that the deceased's death would not have occurred but for the negligence of the defendants.

[11] The defendants' case is that the conservative management approach adopted by the defendants was correct and accepted medical practice and that the deceased's death was not due to the defendants' negligence but due to anaesthetic complications which caused bronchospasm intra-operatively, a risk of operation which had been explained to the deceased and she had consented to go ahead with the operation. This forms the backbone of the defendants' case.

The Law

[12] Previously the test that the defendant doctors had to establish to avoid liability for their acts or omissions was based on the test expounded in *Bolam v. Friern Hospital Management Committee* [1957] 2 All ER 118 also known as the '*Bolam* test'. By this test the defendant doctors could exculpate themselves by showing the following:

(a) That they had acted in accordance with the accepted medical practice and;

(b) That this accepted medical practice of theirs is regarded as proper by a responsible body of medical doctors in that field even if another body of medical opinion takes a contrary view.

[13] Then in the case of *Foo Fio Na v. Dr Soo Fook Mun & Anor* [2007] 1 CLJ 229; [2007] 1 MLJ 593 following the Australian High Court case of *Rogers v. Whitaker* [1992] 175 CLR 479 the Federal Court held that the standard of care that doctors in Malaysia should now exercise is a question which is for the ultimate consideration of the court and no longer one for the medical profession alone to decide through a responsible body of medical opinion. The case also decided that there is a need for members of the medical profession to stand up to the wrongdoings of their fellow professionals so that the courts would be appraised with evidence that would assist them.

[14] When a doctor treats a patient he is not expected to achieve success every time. All that is expected of him is to exercise reasonable care and skill. A doctor cannot be held

negligent simply because something goes wrong. A doctor can be found guilty only if he falls short of the standard of reasonable skilful medical practice: *Payremalu Veerappan v. Dr Amarjeet Kaur & Ors* [2001] 4 CLJ 380. The fact that the patient came out of a hospital in a worse condition than before admittance does not constitute proof of negligence by the hospital staff. One must be able to accept that medical treatment carries a risk and the occurrence of injury is not necessarily evidence of lack of reasonable care: *Foong Yeen Keng v. Assunta Hospital (M) Sdn Bhd & Anor* [2006] 1 CLJ 608. The burden is on the plaintiffs to prove causation: *Wilsher v. Essex Area Health Authority* [1988] All ER 872; *Dominic Puthucheary & Ors v. Dr Goon Siew Fong & Anor* [2007] 5 CLJ 38. In the last mentioned case it was held that medical negligence can be proved by inference from proved facts and equivocal medical evidence may have no bearing in the proof of causation because policy or justice requires that an inference be drawn against the creator of the risk.

[15] The key question is whether the deceased's death can be traced back to the risk created by the defendants in the way they managed the deceased's ectopic pregnancy during the period of her admission at HSA from 13 February 2009 to 20 February 2009.

The Defence

[16] The evidence of the third defendant Dr Siti Muslihat bt Kadir (DW2) is crucial. She was the senior O & G specialist of HSA at the material time and was in charge of the O & G department and therefore the doctor who made the important decisions. In cross examination she admitted to the following:

1. She saw the deceased on 16, 19 and 24 February 2009 even though the deceased was admitted on 13 February 2009.

2. The deceased complained of right iliac pain on and off throughout her stay at HSA and bleeding per vagina (P.V.).

3. The transvaginal scan done during the deceased's stay always showed an empty uterus.

4. On 17 February 2009 the transvaginal scan showed:

   (i) Organized blood clot outside the uterus surrounding the adnexal mass.

A (ii) It also showed a gestational sac measuring 1.06cm x 1.3cm outside the uterus within the adnexal mass.

(iii) Impression was right tubal ectopic pregnancy.

B (iv) The diagnosis after the scan was right tubal ectopic pregnancy.

[17] In defending her decision to adopt the conservative management approach the third defendant explained that she did not want to rush with surgery as every surgery has its risks and C that she had to be sure of her diagnosis before doing so. According to her, before deciding on surgery she had to first decide whether the deceased was having ectopic pregnancy, or an early stage of intra uterine pregnancy, or failing pregnancy. The flaw in this explanation however is that by 17 February 2009 the D deceased's pregnancy had been determined to be ectopic and this was known to the third defendant. In fact when she saw the deceased two days later on 19 February 2009 at 11.40am the impression was still right tubal ectopic pregnancy and the deceased was bleeding with half pad soaked with blood. She knew by her E own admission and indeed as every doctor should that ectopic pregnancy is a dangerous condition that required an emergency operation. Even assuming for the sake of argument that she was still unsure if the deceased's pregnancy was inside or outside the uterus after 17 February 2009, the proper thing for her to do in F the circumstances would have been to do a laparoscopy as according to her that is the best method, the golden rule for determining ectopic pregnancy. There is of course a dispute as to whether she said this in her evidence but in my view and with due respect to the learned Senior Federal Counsel her dissention with G the plaintiffs over the issue is pedantic. It is trite principle that the court does not deal in trivialities. The bigger issue is whether an operation to remove the ectopic pregnancy should have been done once its presence was confirmed on 17 February 2009.

H **[18]** The third defendant admitted that during the deceased's stay at HSA from 13 February 2009 to the date of her discharge on 20 February 2009 there was no indication that she was suffering from URTI. Given the fact that the deceased's pregnancy was confirmed to be ectopic and she was not suffering from URTI, the I big question mark is, why did she not proceed with the operation to remove the ectopic pregnancy? From the record she only attended to the deceased on the 16, 19 and 24 February 2009.

Her last visitation was futile as the ectopic pregnancy had leaked and an emergency operation had to be done at a time when the deceased was having URTI. It appears that the third defendant had left her responsibility to her junior officer the first defendant.

[19] In cross-examination the third defendant maintained that the location of the deceased's pregnancy could not be established, ie, whether it was inside or outside the uterus. This is false because it goes against all findings and recordings in the medical notes of the deceased. The undeniable truth is the location of the pregnancy was known. She also maintained that the deceased was in stable condition throughout, implying of course that the deceased was not facing any emergency situation. This again is untrue as the deceased had pain in her lower abdomen and she was bleeding *via* vagina. It is clear that she was clinically symptomatic throughout her stay at HSA. The source of the pain and bleeding could not be anything else other than the ectopic pregnancy.

[20] After serum bhCG was instituted the third defendant had one plan only and that plan was, if the review of the bhCG level increased to more than 1500, then to do another scan to make sure there was no intra uterine pregnancy and if the scan showed empty uterus then to go for diagnostic laparoscopy. In other words she had no other plan if the bhCG showed a reading of less than 1500 although she herself admitted that the earlier reading from 296 to 1202 was a tremendous increase. She had also failed to appreciate that the quality of the ultrasound scanning machine at HSA was not the best and that was why the discriminating value was taken at 1500 and not lower.

The Expert Opinion

[21] The plaintiffs called two experts, namely Professor Kulenthran Arumugam (PW2) and Dato' Dr Ravindran Jegasothy (PW6) whilst the defendants called one expert, namely Dr Tham Seng Woh (DW4). Both sides have not disputed the expertise of their respective witnesses. I shall deal with the plaintiffs' experts first, starting with PW2 Professor Kulenthran Arumugam. His report is at p. 10-16 of Bundle C. The penultimate conclusion of his opinion on the cause of the deceased's death is encapsulated in the following two paragraphs of his report:

> In my opinion, the crux of the case turns on the events from 13 February to 20th February i.e. her first admission at the Hospital Sultanah Aminah. The management of the patient during that admission set about a trend (sic) of events that finally led to the patient's demise on the 5th of September 2009. Had they managed her appropriately then, on balance, I would think that the outcome may have been different.
>
> To me the blameworthiness lay in the failure of the doctors of HSA to operate on her when the opportunity and indications were there to do so, the patient has suffered the consequences of a 'lost chance'.

[22] PW2 came to this conclusion after noting that the transvaginal scans done at HSA showed:

(i) Normal ovaries.

(ii) Both ovaries were outside the uterus.

(iii) The uterus was empty.

(iv) An adnexal mass 2.1 x 1.1cm with gestational sac was seen outside the uterus.

[23] He testified that given the whole scenario of an empty uterus, a positive pregnancy test, a pregnancy seen on the right fallopian tube, tenderness and vaginal bleeding, any medical student will tell one to consider a right ectopic pregnancy. PW2 explained that unlike the uterus, the fallopian tube cannot keep a growing foetus. In this case there was evidence of such pregnancy in the right fallopian tube during the six days of the deceased's admission. There was ample opportunity for HSA to deal with this life threatening condition but they did not. Instead she was sent home on 20 February 2009 and when she came back bleeding four days later they were forced to carry out the operation under an emergency situation when she already had an upper respiratory tract infection.

[24] PW2 further testified that one must choose the right patient for the conservative management approach. In this case the deceased was not such patient for the following reasons:

(a) She had a period of amenorrhea for six weeks, meaning she had missed her period which is the most common reason for pregnancy.

(b) There was repeated evidence (ultrascans) staring at the doctors that it was an ectopic pregnancy.

(c) Expectant management is an option for clinically stable asymptomatic women with a decreasing bhCG.

(d) The deceased on the other hand was symptomatic, ie, abdominal pain, vaginal bleeding and had tenderness in the right iliac fossa.

(e) At least what the doctors at HSA should have done was to find out and get enough evidence that it was an ectopic pregnancy.

(f) Ultrasound over the period showed an empty uterus, meaning there was no pregnancy inside the uterus. It had to be outside the uterus.

(g) There was adnexal mass seen outside the uterus and referred to as gestational sac, ie, pregnancy. Even the first defendant's impression on 17 February 2009 was a right ectopic pregnancy.

(h) The pregnancy test was positive.

(i) Dr Chu Ah Onn (PW1) the private O & G specialist had also come to the same diagnosis.

(j) The bhCG readings showed an upward trend from the initial reading. Once this was shown the conservative management must be called off because the ectopic pregnancy was not going away (dissolving).

(k) The treatment of choice for ectopic pregnancy is surgery to remove the pregnancy from the fallopian tube and preferably done laparoscopically. The reason is because it is a potentially life-threatening condition and the surgery involved is relatively simple. It is also an accepted principle that where there is a doubt, the benefit of the doubt must always be given to the patient and a diagnostic laparoscopy done. In the present case, the diagnosis was in little doubt. Furthermore the deceased was in stable condition and this was an opportune time to carry out the surgery.

(l) From the time of her admission until her discharge the deceased had shown the two cardinal symptoms of ectopic pregnancy, namely constant complain of pain in the right iliac fossa and continued bleeding through the vagina. That was why she was not the right candidate for conservative management.

(m) Once ectopic pregnancy was confirmed, injection by way of methotrexate could have resolved the ectopic pregnancy.

(n) The deceased could have undergone surgery during her initial stay in HSA from 13 February 2009 to 20 February 2009. This was the optimal condition for the deceased. By this is meant that she was well prepared both by the doctors and herself to undergo the surgery. The conditions were best for her and complications were materially decreased because all the possible complications have been thought of. A good example is if she had contracted URTI at that time the surgery could be cancelled and wait for a better time.

[25] PW2 was subjected to probing cross examination by the learned Senior Federal Counsel but in the end he acquitted himself well. I accept his opinion that the deceased had not been managed appropriately by the doctors at HSA during the period of her admission. I accept his opinion that the deceased had suffered the consequences of a lost chance when the doctors failed to operate on her when the opportunity and indications were there to do so.

[26] The second expert called by the plaintiffs, namely Dato' Dr Ravindran Jegasothy (PW6) is Head of the O & G Department, Hospital Kuala Lumpur. His expert report can be found at p. 1-9 of Bundle C. On the medical terminologies, he explained that normal pregnancy called intra uterine pregnancy is when the fertilized egg implants and develops within the uterus. In ectopic pregnancy the fertilised egg develops outside the uterus, usually in the fallopian tube. An adnexal mass is a mass that involves both the fallopian tube and the ovary. In his report PW6 stated that as an adnexal mass was found on the deceased's admission on 13 February 2009 the diagnosis should be ectopic pregnancy and not pregnancy of unknown origin. PW6 added that looking at the medical notes, the doctors had in fact made a provisional diagnosis of ectopic pregnancy.

[27] It is undisputed that from the date of her admission on 13 February 2009 to the date of her discharge on 20 February 2009, the deceased was complaining of right abdominal pain and was experiencing vaginal bleeding. There was some disagreement over the degree of pain and whether it was continuous but in my view this does not detract from the fact that the pain and bleeding was due to the ectopic pregnancy. The fact is throughout her stay at HSA the deceased had complained of pain of varying degrees, bleeding and tenderness at her right iliac fossa. According to PW6 her symptoms were more than minimal but that is debatable. But the important thing is the location of the pregnancy was known. It was outside the uterus. He added that at p. 29 of the medical notes the impression was 'right tubal ectopic pregnancy'. What this means is that the doctor had made a firmer diagnosis after the earlier provisional diagnosis of ectopic pregnancy. On the bhCG reading, PW6 had this to say:

> My opinion is after the second reading, 1200 on p. 42 of Bundle D1, that is on 15/2/2009 you will find that the beta hCG was 1202. It went up 4 times compared to the first reading. And in the presence of an adnexal mass, when the reading has gone up 4 times, they should have scoped her at that time.

[28] On being questioned by the court on the need for bhCG reading, PW6's explanation is as follows:

> The reason why we do this is, your ultrasound scan has not shown you that the pregnancy is in the uterus. The uterus is empty and the doctor is seeing something outside so now he has to make sure as to whether the pregnancy is inside. Am I not seeing it because it is too early? So the doctor wants 2 days to repeat the test. And in the 2 days the pregnancy would also enlarge and be shown in the ultrascan which you repeat on the second day, so there is the concept of the discriminatory zone. If on the second day the test has come above 1500 or 1000 and you don't see a pregnancy inside the uterus, then that means this is an ectopic pregnancy and a laparoscope must be done to confirm the diagnosis and then do the necessary if the diagnosis is confirmed. That is the reason for bhCG. If this had been confirmed, methotrexate by way of injection could have resolved it.

[29] There is no notation in the medical records of any plan to inject her with the drug methotextrate to resolve the ectopic pregnancy. In this regard it was Professor Kulenthran's (PW2) testimony that methotextrate injection would have terminated the

ectopic pregnancy and that would have been one way to avoid surgery. On the evidence this form of treatment was not considered at all. PW6 confirmed, based on the medical record that the deceased had contracted URTI for two days prior to surgery. The anaesthetist had noted throat irritation and non-productive cough. As she underwent a difficult intubation, this led to the infection going downwards leading to pneumonia and sepsis. In PW6's opinion the leaking ectopic pregnancy directly led to the pneumonia because this was the condition that required the deceased to have the surgery in the first place. According to PW6 the principle of medical management is that you manage it appropriately at the correct time. Any delayed therapy carries its consequences.

[30] PW6 shared PW2's opinion that the circumstances were not right for HSA to take the conservative management approach. He referred to the article *'Guidelines of the Royal College of Obstetricians and Gynaecologists'* (p. 1-9 of Bundle C) where at p. 5 under the heading 'Expectant management of pregnancy of unknown location' it is stated that expectant management is an option for clinically stable women with minimal symptoms and a pregnancy of unknown location. Based on this literature PW6 was of the opinion that the deceased did not qualify for conservative management because the location of her pregnancy was known to be located in a gestational sac outside the uterus in an adnexal mass. In fact this was clearly demonstrated throughout her stay at HSA and which according to PW6 should have been removed before she was discharged on 20 February 2009. PW6 said the other reason why conservative management was not appropriate is because the deceased was in pain and bleeding. In other words she was clinically unstable. In cross-examination he testified that it was wrong for HSA to continue with expectant management as the deceased was symptomatic. When told by the learned Senior Federal Counsel that the ectopic pregnancy had not ruptured, PW6 answered that HSA should not wait for that to happen before deciding to operate.

[31] Evidence on the effect of URTI was given by Dato' Dr Singaravelu Muthusamy (PW5). He is a Consultant Physician at JSH where the deceased was sent to after her operation at HSA on 25 February 2009. He testified that when the deceased was brought to JSH she was in a critical state. She had severe pneumonia and a ventilator failure with a temperature and had difficulty breathing. PW5 explained that in a normal person URTI

is a common event and easily treatable. He said that in the anaesthetics procedure itself during an operation, it is common for any instrumentation to introduce infection into a new area. When an endotracheal tube, which is a tube used for intubation is introduced, naturally bacteria and organism that are present in the throat and upper respiratory tract will be introduced into the lower respiratory tract. This according to PW5 is common knowledge. He added that URTI if introduced into the lower tract may lead to pneumonia. The fact that the deceased underwent an operation, ie, laparotomy would have compromised her body's ability to recover from this infection:

(i) because of the condition, meaning the leaking ectopic pregnancy which caused the problem requiring surgery;

(ii) because of anaesthesia; and

(iii) because of a post-operative state.

[32] The deceased came to JSH with a post-operative hospital acquired bilateral pneumonia from HSA, which means pneumonia in both lungs. PW5 likened bilateral pneumonia to 'kicking a can down the road', meaning to say eventually it will develop serious complications. He explained that when you put people on ventilator due to respiratory failure from the first pneumonia you can always develop other infections. This is part and parcel of using mechanical ventilation. This happened at JSH as a result of complications in the treatment of her pneumonia which was very difficult and very resistant and rapidly progressive. Whenever an infection develops as a subsequence of an operation and as a subsequence of an intensive care unit, it is called nosocomial infection which the deceased had acquired at HSA. PW5 testified that when the deceased was re-admitted to HSA she had multiple chest tubes, five in number in order to keep the lungs in an expanded state and in a situation where the oxygen was adequate. In cross-examination PW5 was asked if the complications had occurred at JSH. He denied the suggestion and said that it was complications that you see in some pneumonia which is irreversible and difficult to treat.

[33] On 24 February 2009 when the deceased came back to HSA after being discharged on 20 February 2009 it is obvious that her ectopic pregnancy had leaked and she was suffering from URTI. The URTI should have been observed at the O & G ward on 24 February 2009. But for some unexplained reasons it was

not detected by the doctors. If it had been observed, treatment could have started on that day itself. But no such treatment was given as evident from the medical notes. Learned Senior Federal Counsel stressed the point that Professor Kulenthran (PW2) himself accepted that the deceased might well have developed the same anaesthetic complications if she had been operated on her first admission between 13 February 2009 and 20 February 2009. With due respect the point is moot as it is an undisputed fact that the deceased did not suffer from URTI during that period.

Defence Expert

[34] I now come to the evidence of the expert called by the defendants, namely Dr Tham Seng Woh (DW4). He is the Senior Consultant and Head of the O & G department, Hospital Melaka. At the trial he produced the document marked D7 which contains his comments on the particulars of negligence raised by the 'complainant' at pp. 11-13 of the Bundle of Pleadings and his comments on the expert opinion of PW2 and PW6 as contained in their reports. First of all, pleadings are not evidence. It is incomprehensible why a witness would want to comment on pleadings which in any case were denied, which means the allegations were subject to strict proof by the plaintiffs.

[35] It was DW4's argument that because the deceased was treated at specialist level, no complaint can be made of the treatment rendered. I do not see how this factor has any relevance to the question of whether the deceased had been properly managed by HSA. DW4 said it can be argued that no definitive action should be taken when the bhCG level went up to 1202 (from 296) because there was no definitive sign of ectopic pregnancy and that expectant management was still an option. With due respect to DW4 he should not be talking about definite sign when all days from 13 February 2009 to 20 February 2009 the provisional diagnosis had always been ectopic pregnancy and on 17 February 2009 it was firmly confirmed to be ectopic pregnancy. Ectopic pregnancy was also foremost in the minds of the doctors. DW4 even wrongly claimed that tubal ligation was not performed on the deceased as no consent was given by the deceased and her husband when there is clear evidence that they had in fact given their consent. Why it was not done is a mystery. He asserted that the adnexal mass could be a haemorrhagic corpus luteal cyst (and therefore not necessarily an ectopic pregnancy) but nowhere in the medical notes is there any suggestion of

corpus luteal cyst. In any event DW4 agreed under cross-examination that a corpus luteal cyst can only be found on the ovaries and in this case the ovaries were found to be normal, which means there was no cyst.

[36] DW4 went on to say that all the complaints of the deceased such as constant pain, vaginal bleeding together with empty uterus and gestational sac can be features of:

(i) Early pregnancy.

(ii) Threatened miscarriage.

(iii) Normal uterine pregnancy.

(iv) Incomplete miscarriage.

(v) Haemorrhagic corpus luteal cyst.

(vi) Bowel syndrome.

(vii) Swollen fallopian tubes.

(viii) Even the result of adhesion.

[37] None of these except ectopic and normal uterine pregnancy was mentioned by the doctors at HSA. The provisional diagnosis was either normal or ectopic pregnancy and none of those others mentioned by DW4. It is perplexing why DW4 would come up with such an array of differential diagnosis. DW4 admitted that in public hospitals such as HSA the ultrasound for scanning has no high resolution and that in the absence of high resolution scan, diagnostic laparoscopy is the definitive diagnosis method. What this means is that HSA should not have relied too much on transvaginal scan to diagnose the deceased's ectopic pregnancy. Even though diagnostic laparoscopy is no longer the 'gold standard' in determining ectopic pregnancy, it was the best in the circumstances and the procedure that the defendants ought to have adopted instead of using low resolution scanning instruments to diagnose the deceased's pregnancy.

[38] With due respect to DW4 his evidence does not inspire confidence at all. The distinct impression I get is that he was more concerned with defending the actions of the O & G doctors at HSA rather than to assist the court in finding the truth.

Therefore where his opinion is at divergence with the opinion of the plaintiffs' experts I prefer the opinion of the latter as being more credible and reliable. They impressed me as witnesses of truth.

Conclusion On Liability

[39] Having regard to the totality of the evidence and the probabilities of the case it is my finding that the risk of anaesthetic complications was created by the defendants when they failed to operate on the deceased immediately or so soon after it was confirmed on 17 February 2009 that the deceased was having an ectopic pregnancy and when the condition was optimal for her to undergo the operation. It was negligence by omission. If surgery had been performed before her discharge on 20 February 2009 the anaesthetic complications would not have arisen and the surgery on 25 February 2009 would not have been necessary at all. While it is true that the URTI that the deceased contracted after her discharge on 20 February 2009 was something beyond the defendants' control, the necessity to perform the emergency operation on 25 February 2009 was something that could easily have been avoided. By omitting to operate on the deceased before discharging her on 20 February 2009 the defendants had provided the causative link to the anaesthetic complications which eventually led to the deceased's death. For this reason it is untenable for the learned Senior Federal Counsel to argue that the same anaesthetic complications might have happened if the deceased had been operated on before her discharge on 20 February 2009. The suggestion is speculative at best. Further, the throat irritation and non-productive cough for two days that the deceased was having prior to the emergency surgery should have been observed by the doctors on 24 February 2009 when the deceased was re-admitted but they were not. Thus no treatment at all was given for her URTI. The fact that bronchospasm is a risk of operation which had been explained to the deceased and that she had consented to go ahead with the operation cannot absolve the defendants of liability if otherwise they were negligent in creating that risk. On a balance of probability therefore the defendants are liable in negligence for the death of the deceased.

Damages

[40] I shall deal with the issue of damages in the order submitted by learned counsel for the plaintiffs in his submissions, as follows:

Funeral Expenses

[41] The court can take judicial notice of funeral expenses being normally incurred and to award a reasonable and fair sum for such expenses according to the status of the deceased: *Pang Ah Chee (M.W) v. Chong Kwee Sang* [1985] 2 CLJ 221; [1985] CLJ (Rep) 236; [1985] 1 MLJ 153. I awarded RM5,000 under this head.

Bereavement

[42] It is not disputed that the deceased was married to the fifth plaintiff when she died. Her husband is therefore entitled to an award for the statutory bereavement under s. 7(3A) and 3(B) of the Civil Law Act 1956 ('the Civil Law Act'). RM10,000 under his head.

Loss Of Support To The First And Second Plaintiffs

[43] The first and second plaintiffs are the parents of the deceased. They are entitled to claim for loss of financial support if there is evidence of such support by the deceased: Malaysian Personal Injury Service (2005) at p. III 9. The deceased was working as a general clerk earning RM1,200. There is evidence that she gave RM300 monthly to her parents for financial support and RM150 for provisions and marketing expenses. The evidence on the dependency sum was not disputed at the trial. As the deceased was 31 years old, the statutory multiplier is 55-31=12 years (144 months). RM43,200 (RM300 x 144 months) was allowed under this head as against the claimed sum of RM64,800 (RM450 x 144 months). I have disallowed the claim for provisions and marketing expenses of RM150 per month.

Loss Of Support To The Third And Fourth Plaintiffs

[44] The third and fourth plaintiffs are the deceased's children. The unchallenged evidence is that the deceased spent about RM600 per month for her children, which is now lost with her death. RM86,400 for this item (RM600 x 144 months).

Loss Of Services Of The Deceased Mother To Her Two Children

[45] I awarded RM12,600 for this item. 'Services' not only refers to housekeeping and daily chores at home but includes personal care and attention that she was giving to her children. It is in recognition of the services that she gave gratuitously. A mother does not work set hours. She is in constant attendance. She gives the child nursing and care on their well being, character and education. In estimating the value, the costs of hiring a maid can be used as a guide, with adjustments to reflect that the mother's services is much more than the services that the maid provides: *Atkins Court Forms Malaysia* Vol. 9 p. 152-153; *Chong Pik Sing & Anor v. Ng Mun Bee* [1985] 1 CLJ 332; [1985] CLJ (Rep) 70; [1985] 1 MLJ 433; *Hum Peng Sin v. Lim Lai Hoon & Anor* [2001] 4 CLJ 185.

[46] The deceased had two very young children at the time of her death, a daughter eight years old and a son five years old. The family had no maid and the deceased personally attended to the children's daily needs upon returning home from work. During her working hours, the children were taken care of by her parents. She did the cooking, washing clothes, teaching and nursing them and attending to their needs. These were not disputed at the trial.

[47] After the deceased's death, the fifth plaintiff (her husband) is personally taking care of the children and attending to their needs. He did not hire a maid. Although he has remarried, he is still personally taking care of them and attending to their needs after his working hours. He said he is not relying on his new wife as she has her own family commitments and has made clear to him even before their marriage that she cannot be depended on to take care of the children. The evidence is not disputed at all. During his working hours, the children are left at the daycare center for which the fifth plaintiff is paying RM300 per month. The evidence is also not disputed at all.

[48] It is now trite law that damages can be given for services rendered gratuitously by family members like parents or the surviving spouse. A value can be attached to the services and awarded as damages: *Marappan Nallan Koundar & Anor v. Siti Rahmah Ibrahim* [1990] 1 CLJ 32; [1990] 1 CLJ (Rep) 174; [1990] 1 MLJ 99; *Devadass Raju v. Tham Soon Kum* [2013] 7 CLJ 178; [2013] 1 MLJ 700. In this regard I agree with learned counsel for the plaintiffs that the court can take judicial notice of

the fact that currently the cost of employing a maid including the agency deposit and expenses et cetera can reach RM1,200 a month. As for the multiplier, the Supreme Court in *Chong Pik Sing & Anor v. Ng Mun Bee* (*supra*) held that the mother's services would reasonably be required until the children reach 18 years and this was the basis for arriving at post-trial multiplier of eight years. The plaintiffs' suggestion which I am in agreement with is as follows:

Pre-trial Loss - 4 Years

[49] Post-trial loss - 8 years as the multiplier for both children, as the elder child (now 12 years old) has six years and the younger child (now nine years old) has nine years respectively before reaching 18 years. The total multiplier is therefore 12 years (144 months).

[50] There is also an additional expense that is being incurred by the fifth plaintiff in the sum of RM300 per month for the daycare of the two children. Under s. 7(3) of the Civil Law Act, damages can include 'for any loss of support together with any reasonable expenses incurred as a result of the wrongful act...'. The sum awarded for day care expenses for the two children was RM21,000.

Nursing Care Of The Deceased

[51] It is now trite law that damages can be given for nursing care, including at home, even when the care was provided by family members gratuitously: *Marappan Nallan Koundar & Anor v. Siti Rahmah Ibrahim* (*supra*). RM3,400 awarded under this head.

Transport Expenses For The Plaintiffs To Visit The Deceased At The Hospital

[52] The plaintiffs claimed for a sum of RM17,400 but in my view a more reasonable sum would be a sum of RM6,600, which was the sum I awarded.

Medical Expenses At Hospital Sultanah Aminah

[53] This was agreed at RM557.

Medical Expenses At Johor Specialist Hospital

[54] This claim is for a sum of RM142,515.55 and is supported by the bills at p. 22-24 of Bundle B. There is no dispute as to the sum claimed and is in fact confirmed by PW7, the accounts officer of JSH. The only issue is whether it is reasonable to award the sum as it was incurred at a private hospital. It is a fact that the deceased was not immediately taken to the private hospital. She was admitted to a government hospital between 24 February 2009 to 4 March 2009 before the family, in desperation and disappointment with the care given there, decided to take her to the private hospital.

[55] The deceased and her husband had looked to the government hospital for treatment but they were let down. It was only when her condition deteriorated and there was no sign of improvement that the family took her to the private hospital. They did so even when they could not afford the treatment costs. The manner by which the costs were paid shows that the family was struggling for money to pay the bills.

[56] Although the treatment at the private hospital could not be completed due to the family's inability to meet the costs and the deceased subsequently died, their attempt to save her by transferring her to the private hospital is still a reasonable action under the circumstances. She was a young lady with two young children and every attempt to save her is merited and cannot be excessive. In the unreported (as yet) decision of the Court of Appeal in Civil Appeal No: J-01-113-03-2012 the court allowed medical expenses at a private hospital when the plaintiff was transferred from the government hospital and also allowed the future treatment coats at a private hospital. In that case the plaintiff was injured in a road traffic accident and was admitted to Hospital Batu Pahat and Klinik Kesihatan Yong Peng. Both hospitals failed to detect that there was a hip fracture. Subsequent medical examination showed that the plaintiff will have to undergo total hip replacement surgery. The plaintiff filed a claim for negligence against the government hospital and amongst others, claimed for costs of treatment at a private hospital as she had lost confidence in the government hospital following their failure to detect the hip injury. The High Court dismissed the sum for that item but on appeal the Court of Appeal awarded the medical expenses in full. On the facts and on the authority of this Court of Appeal decision I allowed the plaintiff's claim of RM142,515 in full under this head.

Costs Of Adult Diapers

[57] The sum of RM1,200 claimed was allowed as it is undisputed that after the operation on 25 February 2009 and when she became unconscious shortly thereafter and until her death on 5 September 2009 the deceased lost her bladder and bowel control and was on diapers. This was about six months. The family spent RM150 - RM200 on this. Damages for this item can be awarded without insistence on documentary proof: *Atkins Court Forms Malaysia* Vol. 9 p. 258.

Costs Of Special Milk

[58] The RM1,200 claimed was likewise allowed as it was not disputed that the deceased was fed with a special milk through the tracheostomy tube. This was her only source of nutrient. About RM200 was spent monthly by the family. No documentary proof required: *Atkins Court Forms* (ante).

Medical Report Charges

[59] RM68 allowed.

Pain And Suffering Endured By The Deceased

[60] This claim comes under s. 8 of the Civil Law Act 1956. There can be no doubt that the deceased suffered pain and suffering in the hospital for about seven months until she died. In *Jennifer Anne Harper v. Timothy Theseira* [2009] 2 CLJ 499; [2009] 7 MLJ 711 the deceased, a 68 year old man, suffered severe head and brain injuries and was bedridden from the accident until his death nine months later. The Sessions Court found that 'the deceased was not entirely in a state of coma though most of the time unconscious' and 'aware of surroundings' plus the fact of being bed ridden for nine months and awarded RM150,000 for pain and suffering. The award was upheld on appeal.

[61] In determining the proper award for this item I have taken the following into consideration:

(a) The deceased was alive for about seven months in a bedridden condition although she was conscious.

(b) The deceased was not in a state of coma. She still had to be fed and changed. Her bladder and bowel movement was still present.

(c) She was already struggling with abdominal pain from 13 February 2009 until she was operated on 25 February 2009 before falling unconscious.

(d) She had experienced continued blood loss through her vagina for days even when she was in the hospital bed before the operation.

(e) She was subjected to various treatments and invasive procedures as part of her treatment at HSA and JSH.

(f) Even when she was discharged she was placed with tracheotomy tube and Ryle's feeding tube.

(g) Her bedridden condition also led to the development of sacral bed sores which was one of the causes of death.

[62] Having regard to the above considerations I am of the view that an award of RM150,000 for pain and suffering would be fair and reasonable and I have so ordered.

[63] In total the sum awarded to the plaintiffs is RM484,990.55. Interest on general damages was fixed at 5% per annum from the date of service of the writ of summons to the date of judgment, 2% per annum for special damages from 25 March 2009 till date of judgment and 5% per annum on the judgment sum from the date of judgment to the date of full settlement.